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The Healthcare Bulletin

MS Clarifies Guidelines for National Provider Identifier (NPI) Deadline Implementation

The Centers for Medicare & Medicaid Services (CMS) announced that it is implementing a contingency plan for covered entities (other than small health plans) who will not meet the May 23, 2007, deadline for compliance with the National Provider Identifier (NPI) regulations under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Information and education on the NPI can be found on the CMS Web site at the CMS NPI page: <http://www.cms.hhs.gov/NationalProvIdentStand/> You can apply for an NPI online at: <https://nppes.cms.hhs.gov/> or you can call the NPI enumerator to request a paper application at (800) 465-3203.

Georgia False Medicaid Claims Act

House Bill 551 has passed the senate and house and is awaiting Governor Sonny Purdew's signature. The bill provides for the "State False Medicaid Claims Act". To read the entire bill go to: http://www.legis.state.ga.us/legis/2007_08/pdf/hb551.pdf.

Administrative Presumption of Coverage

CMS has established a policy that, when the initial Medicare required assessment results in a beneficiary being correctly assigned to one of the upper 35 RUG groups, this creates a presumption of coverage for the period from the first day of the Medicare covered services up to, and including, the assessment reference date for that assessment (which may include grace days). This presumption does not arise in connection with any subsequent assessments.

Administrative presumption of coverage does not exist for a beneficiary who is correctly assigned into one of the lower 18 RUG groups on the initial 5-day assessment, so documentation must support that these beneficiaries meet the level of care requirements. (Source: CMS Pub 100-08 Medicare Program Integrity, Transmittal 196.)

Documentation Hints

Documentation supporting medical necessity should be legible and provided to the Medicare contractor upon request. The medical

necessity for daily skilled services must be documented clearly. Therapy documentation needs to reflect that the beneficiary can actively participate and retain instructions. Diagnosis/(es) submitted on the claim must be coded to the highest level of specificity.

Skilled Nursing Facilities' Involvement in Consecutive Inpatient Stays

The OIG (Office of the Inspector General) will determine whether SNF care provided to Medicare beneficiaries with consecutive inpatient stays was medically reasonable and necessary. The study will focus on beneficiaries who experience three or more consecutive stays, including at least one SNF facility stay. The OIG will also examine the extent and nature of consecutive Medicare hospital inpatient stays. (Source: HHS OIG FY 2007 Work Plan).

MDS Item K5 Nutritional Approaches

When completing MDS item K5 remember that Parenteral/Intravenous (IV) include only fluids administered for nutrition or hydration. IV medications are not included for coding this item. Refer to the Resident Assessment Instrument (RAI manual Page 3-153 for definitions and examples.)

Medical Review of Skilled Nursing Facility Part A Claims

Beginning April 30, 2007, Medicare Contractors (Fiscal Intermediaries and Program Safeguard Contractors) must use a new, automated MDS QC System Software to review and calculate correct RUG values for Part A SNF claims with dates of service beginning January 1, 2006. Medicare Contractors will utilize the MDS extract tool to obtain electronic copies of MDS assessments from the state repository. The MDS data will be imported into the MDS QC Software System and converted and reformatted. The Medical record will be reviewed and the reviewer will make coding changes as necessary to the provider submitted MDS. The claim will be paid according to the RUG-III value calculated by the MDS QC tool, and any applicable over payments will be recouped.

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